

## Patient History Sheet

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Reason for visit \_\_\_\_\_

Local Pharmacy Name \_\_\_\_\_ Pharm Phone \_\_\_\_\_

Address \_\_\_\_\_

Mail Order Pharmacy \_\_\_\_\_

**Please circle yes if you have or have had the following**

Anxiety	Y	N	Glaucoma	Y	N	Kidney Problems	Y	N
Arthritis	Y	N	COPD	Y	N	MRSA	Y	N
Hay fever	Y	N	Depression	Y	N	Heart Attack	Y	N
Hives	Y	N	Diabetes	Y	N	Psoriasis	Y	N
Asthma	Y	N	Emphysema	Y	N	Seizure Disorder	Y	N
Bipolar	Y	N	Hearing Loss	Y	N	Sleep Apnea	Y	N
Bleeding disorder	Y	N	Heart Disease	Y	N	Stroke	Y	N
Bronchitis	Y	N	Blood pressure Probs	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Joint Replacements	Y	N	ringing in Ear	Y	N

Any other Medical Problem? \_\_\_\_\_

Have you ever had any surgeries?(List) \_\_\_\_\_

Drug Allergies	Y	N	List
Environmental Allergy	Y	N	List
Food Allergies	Y	N	List
Latex Allergy	Y	N	Adhesive Allergy    Y    N
Do You Currently Smoke	Y	N	How Much
History of smoking	Y	N	How Much                      How Long
Drink Alcohol	Y	N	How Much

**Please List Medications and Dosages**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Review of Systems - Please Circle all that Apply**

<i>General</i>	Feeling Well	Weight Loss	Fever	Night Sweats
<i>Skin</i>	Bruising	Itchy Skin	Rash(es)	
<i>HEENT</i>	Blurred Vision	Double Vision	Dizziness	Hearing Loss
	Ear Discharge	Ear Pain	ringing in Ears	Seasonal Allergies
<i>Neck</i>	Swollen Glands			
<i>Respiratory</i>	Cough	Snoring	Wheezing	Bloody Sputum
<i>Cardio Vascular</i>	Chest Pain	Leg Pain/Swelling	Shortness of Breath	
<i>Gastrointestinal</i>	Black/Tarry Stool	Constipation	Diarrhea	Heartburn
<i>Genitourinary</i>	Urinary Complaints	Prostrate Issues		
<i>Musculoskeletal</i>	Muscle Pain			
<i>Neurological</i>	Headaches	Weakness in arms/legs		
<i>Hematology</i>	Abnormal Bleeding	Easily Bruising	Nose Bleeds	